LOUISIANA PATIENT'S COMPENSATION FUND

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Opportunity for Change

By F. Dean Griffen, MD
Chair, LPCF Oversight Board

Health care providers in Louisiana can be thankful. In response to the first ever medical liability crisis, in the 1970's Louisiana was among a handful of states to enact medical tort reform that would, over time, prove to protect patients' access to care and health care providers' access to affordable liability insurance.

Our system, like others that are successful, includes a cap on non-economic losses. Since the 70's, liability problems have been ongoing, resulting in tort reform that includes caps in many other states. Some caps are virtually impotent because of exceptions. For example, in Massachusetts, any jury or judge can opt out of the cap at their own discretion. Even so, including all states with caps of any kind, liability insurance is more affordable and more available. In the January 2004 issue of Health Affairs, the Rollins School of Public Health at Emory University published results of their research, finding that premiums are 17.1 percent lower on average in states that cap awards than in states without caps.

Caps on non-economic losses also have a profound effect on access to care. A study by the Agency for Healthcare Research and Quality (AHRQ) showed that states with caps increased their physician supply on average 95.7% between 1970 and 2000 while states without caps increased only 79.1%. This has resulted in a 12% advantage in physicians per capita for states with caps (135/1000 compared to 120/1000).

Successful state legislation across the country has intensified the national crisis, spawning mal-distribution of the physician workforce and creating underserved populations in geographic areas where liability insurance costs are prohibitive. Residents training in crisis states leave after training, opting to practice in areas less stigmatized. For example, Pennsylvania, a crisis state, has dropped from 12th to 38th in states with physicians less than 35 years of age. Pennsylvania-trained residents stayed in Pennsylvania to practice 51% of the time in the past but now that percentage has dwindled to 8%. There is no longer a neurosurgeon in Southern Illinois, severely limiting emergency care in that area. Medical students opt out of high-risk specialties. For example, for three years in a row, the number of medical students entering obstetrical residencies has decreased, according to data from the American College of Obstetrics and Gynecology (ACOG). A study by the Center for Studying Health System Change demonstrated that patients with private insurance, seeking access of last resort, caused a 16% increase in emergency department visits between 1997 and 2001. In 2002 Massachusetts emergency departments were on diversion 8,000 hours compared to 14,619 hours in 2004. These examples of access to care problems are just the peak of the iceberg and foretell of greater problems for the future.

Federal tort reform is needed to protect patients and health care providers in crisis areas. The House of Representatives has passed medical tort reform legislation, including caps on non-economic loses, yearly. The Senate has failed to act. Currently, there are fifty-two of the sixty votes needed in the Senate to defeat the annual filibuster and bring the proposed law to the floor for debate. Public policy groups, including

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coalitions made up of parties from medicine, insurance, and business, are hard at work to alter the balance. No end is in sight. Even if federal tort reform is achieved, it can only improve access to care for patients and control liability insurance cost and availability for health care providers. Unfortunately, tort law, by its very nature, can never be corrected to eliminate many other flaws inherent in the system:

- It discourages the reporting and evaluation of errors, which could otherwise be used to evaluate and improve care.
- Six dollars out of every ten paid in premiums go to lawyers and administrative costs instead of injured patients.
- Costly defensive medical practices are encouraged.
- Awards to injured patients are delayed for years.
- Severe psychological stress is imposed on physicians during litigation and many retire early or change their practices to exclude procedures which are most efficacious but also highly litigious.
- Eight out of ten suits are without merit because of the legal feeding frenzy the system encourages.
- As few as two percent of medical injury victims file a claim and hence many receive no award while others are inexplicably the undeserving beneficiaries of jackpot justice.
- 40% of paid claims stem from suits against defendants that actually meet the standard of care.

To mitigate these problems, experts in the field, including Philip Howard, an attorney who founded Common Good, have worked to design and promulgate a system of medical courts to replace the tort system entirely. These policy makers argue convincingly that trained judges must render verdicts in cases involving medical liability, relying on unbiased experts. Currently, so often a biased expert for the defense and an equally biased expert for the plaintiff face off before a jury and a judge neither of which has the ability to evaluate the claim from a scientific perspective. A system of medical courts would eliminate juries. A judge, expert in medical claims, would preside over the proceedings and would personally select the medical experts based on their credentials, not their biases. Selection bias on the part of the defendant and plaintiff would be eliminated. Working with the Harvard School of Public Health, Common Good continues to grapple with the many other permutations of medical courts, including interesting ways to introduce the concept as a pilot study. Innovative ways to avoid jackpot justice, identify injured patients for appropriate awards, speed the process, and defuse the current culture of blame and fault are being enumerated. For a comprehensive look at this issue, go to http://cgood.org.

Neither federal tort reform nor medical courts are eminent; their pursuit is a work in progress. In the meantime each of us must be a well-informed advocate. Who knows what straw will break the camel's back? In the meantime for a change, Louisiana is first, not last; we enjoy the best system currently available. The members of the Oversight Board and staff of the Patients' Compensation Fund are privileged to be a part of the system and are committed to the welfare of the Fund's insured and their patients.

PCF Records

The Records section at PCF is responsible for housing and maintaining all panel, claim and provider files. At this time there are only 2 full time employees in the Records section, Cathy Moss, Records Manager and Veniayetta Aikens, File Clerk. There are also 5 student workers who help copy and file. All copy requests are processed by the Records Manager following the public records laws of Louisiana, HIPAA guidelines and attorney general opinions concerning the confidentiality of records. The Records Manager at the PCF is also a notary, so we can provide notarized documents as needed. If you have a document request, please submit your request in writing via email to Cathy Moss at cathy.moss@la.gov , via fax to Cathy at (225) 342-9699 or by mail at P.O. Box 3718, Baton Rouge, LA 70821. If you have any questions regarding records, please call Cathy at (225) 342-6032.

From the Director

By Lorraine LeBlanc, PCF Executive Director

The PCF completed the presentations that were scheduled across the State in Fall 2005. Unfortunately, the turnout was less than expected, due in part to the hurricanes. However, we still feel it was a worthwhile endeavor as those who did attend were able to meet the staff and obtain important information, as well as have an opportunity to get answers to any questions.

PCF was granted a rate increase effective January 1, 2006. Hospitals and Nursing Homes had an increase in rates of 6.9%, while physicians had an increase ranging from 6.7% to 9.5%. There was a significant decrease in some advanced practice nursing specialties; Nurse Practitioners had a decrease of 73.4% and Physician Assistants and Surgical Assistants had a decrease of 53.4%.

PCF has experienced a slow, but steady increase in the number of claims filed each year. In 1995, there were 1626 panel requests filed, while in 2005 there were 2161. As the number of claims filed grows, so does the amount the PCF pays out in claims. Our budget for claims has grown from $75,000,000 in 2002 to $80,000,000 in 2003 through 2005 and we feel this amount is insufficient for 2006. The PCF has requested a $17,000,000 increase in our current budget in order to ensure we are able to pay all settlements and judgments that become due during the current fiscal year which ends June 30, 2006. The claims budget includes the costs of defending claims and the payment of ongoing medical expenses, as well as settlements and judgments. The PCF is very mindful of the impact our actions have on the rates paid by health care providers and we make every effort to ensure payments are justified. Even with these payments our administrative costs are only 7.7% of our overall expenditures.

Lorraine LeBlanc, Executive Director

What the future may bring is certainly unknown in light of the damage done to the health care community by the hurricanes. However, the PCF has been working with health care providers to help them maintain proper coverage. We have enacted rules to accomplish this. The emergency rules are posted on our web site which is located here: http://www.lapcf.louisiana.gov . We encourage health care providers, insurers and insurance agents to contact the office if they have any questions regarding coverage, or any other matters.

Healthcare Providers Affected By Katrina & Rita

The PCF understands that this has been a very trying time for all affected by the hurricanes. Please contact this office with a new address and telephone number where you can be reached, whether temporary or permanent. It is extremely important that this office know the whereabouts of health care providers so that proper notice of any claims can be made. Often, an underlying policy requires notice from the health care provider of a claim during the policy period and failure to timely notify the insurer by the provider could result in denial of coverage.

Emergency Rule 2 (LAC 37:III.115) was established by the Patient's Compensation Fund Oversight Board to aid those healthcare providers affected by Hurricanes Katrina and Rita. The rule allows additional time for payment of a healthcare provider's PCF surcharge. The deadline for payment of either coverage renewal or the purchase of an extended reporting endorsement was March 1, 2006. This means if your PCF coverage was set to renewal between August 29, 2005 and January 31, 2006, some sort of payment was due by March 1st.

If you had trouble meeting this deadline, please contact the office and we will try to work out a resolution.

NOTICE TO ALL HEALTH CARE PROVIDERS AND INSURERS

It is very important that the PCF get **complete** names, dates of birth and license numbers so that we can properly identify health care providers. With the numerous moves and relocations taking place as a result of Hurricanes Katrina and Rita, it is difficult to know whether a particular provider is a new provider or a current provider that is changing locations and/or practice specialties when there are similar names and no middle name or other identifying information given. Providers must include **all** information on applications and insurers/agents should include **all** information on certificates of insurance.

Change

By Gaye Smith, PCF Administrative Director

To paraphrase Benjamin Disraeli, ***"Change is inevitable. In a progressive country {or business} change is constant."***

Change can be defined as: (1) To cause to be different; (2) To give a completely different form or appearance to; transform; (3) To give and receive reciprocally; or (4) To exchange for or replace with another, usually of the same kind or category.

The world has seen many changes recently. A hundred years ago, there were no cars, no television, and travel through the air, much less space, was a laughable prospect. At the risk of dating myself, during my lifetime, I have seen telephone usage change from party lines (multiple households using the same connection) and rotary dial phones to cell-phones and internet phone calls; music produced from 78RPM record albums in stereo cabinets the size of your washing machine to IPODS smaller than the palm of your hand; and computers change from room size units to laptops the size of a tablet of paper. Office technology has progressed very rapidly and the way business is handled today has seen major changes. Fifteen years ago, my computer use consisted of occasional use of a dumb terminal for a couple of hours a week. Now, many offices are so "plugged-in", employees almost cannot function if their computers are not available.

The PCF has seen many changes, as evidenced in our last newsletter. We have grown from a $30 Million budget and 21 employees in 1990 to an $80 Million budget and 43 employees in 2006.

Now, PCF is on the brink of major changes in our Information Technology. We are replacing our current computer system with a system integrated with our Document Management records. We hope to automate such processes as making payments through Electronic Funds Transfer (EFT), providing data on our website so that credentialing entities will be able to access the information, and electronic submission of applications for self-insured health care providers.

> ***"Change is inevitable. In a progressive country {or business} change is constant."***

While many of the features of PCF's system will be most beneficial to PCF employees, some of the changes will affect those who supply information to the PCF. For instance, complete and accurate data must be collected regarding health care providers **before** it can be entered into the new system. The consequences of not providing this information may include a delay in enrollment of a health care provider. This information might be such items as the date of birth of a provider, a provider's middle name, or separate billing and correspondence addresses. Most of the required data elements have not yet been identified. Once they are known, the PCF will be providing information to those suppliers of information so they will have time to adjust to including the necessary information.

If anything is certain, it is that change is certain. The world we are planning for today will not exist in this form tomorrow.
Philip Crosby, Reflections on Quality

PCF is taking a pro-active stance to the innovations available in today's technology in order to assist our employees in performing their jobs at the highest levels attainable. We feel that it is our **duty** to be ***efficient, effective, accurate and timely*** in our services to our customers. Fifteen years down the road, the innovations we are embracing in our current Information Technology upgrade will undoubtedly be as outdated as that dumb terminal I used 15 years ago. However, for now, this new technology offers many advantages in serving our customers.

Legislation and the PCF

The First Extraordinary Session in 2005 has concluded and the PCF has made the necessary changes in procedures in accordance with the mandates of Act 6, which allowed for suspensions and extensions of some legal and administrative deadlines. Most of those deadlines have ended; however, the Act did have provisions for further extensions of some deadlines. The Act should be reviewed for further information regarding this matter. A link to the Act can be found on PCF's website here:
http://www.lapcf.louisiana.gov/

The First Extraordinary Session in 2006 did not really bring about any changes that had any impact on the PCF.

The upcoming 2006 Regular Session is sure to include bills to make changes in the statutes that govern the Medical Malpractice Act and the Patient's Compensation Fund. While the PCF will monitor and participate in discussions regarding any legislation involving the Medical Malpractice Act, as a State agency, we are not allowed to lobby for or against any bills. The PCF can be called upon by the Legislators to provide information or to answer questions at the time the bills are being discussed in committees. In the past, we have worked with the various interests in the formation of legislation and will continue to do so. Should any parties have concerns about proposed legislation dealing with the Medical Malpractice Act or that might impact coverage for health care providers, please contact the Executive Director.

PCF Oversight Board Changes

After serving on the Board since its inception in September 1990, Dr. Charles Belleau, now retired, served on his last Board meeting in January 2006. He was presented with a gift at the Board meeting as a token of appreciation for the many years he earnestly pushed to make the Louisiana PCF one of the best funds in the country. Under his watch, the PCF became financially stable; assuring it will be in existence in the future, for both the health care providers and those persons who have suffered a loss due to medical malpractice.

New Board members were appointed to the Board and sworn in during the January and February 2006 meetings. They include Dr. Kenneth Brown representing physicians, Dr. William Schumacher representing physicians, Mr. Manual DePascual representing insurance companies and Ms. Dionne Viator representing hospitals.

The PCF Oversight Board meets the first Thursday of each month at the Woman's Hospital Physician Tower, Corporate Conference room. The agenda for each Board meeting is posted on the PCF website on Wednesday prior to the meeting. The General Session of the meeting is open to the public.

Economic Viability of the Fund

If you were to view the financial records of the Patient's Compensation Fund (PCF) as if it were a traditional insurance company, then you might question the fiscal soundness of the entity. However, if you view the financial records of the Patient's Compensation Fund as a specially created entity designed to pay claims, settlements and judgments, then you will likely view the Fund as fiscally sound. All settlements and judgments have been paid in full by the Fund since its creation. The Fund has consistently met all its obligations. In addition, the financial stability of the Fund has been significantly improved since 1990 when the Oversight Board was created by the state legislature.

The Fund's fiscal soundness is subject, in part, to surcharge collections. Requests for rate increases must be presented to and approved by the Department of Insurance. An annual actuary study is done to determine the need for any rate increase. This recommendation is discussed by the Patient's Compensation Fund Oversight Board and a determination is made as to whether or not a rate increase is justified. There have been years in which the Insurance Rating Commission has denied rate increases. This usually resulted in higher increases the next year.

Another factor impacting the fiscal soundness of the Fund, which is outside of the control of the Fund, is enrollment. Participation in the Fund is voluntary. There is no guarantee that the enrollment will remain the same year to year. Further, the Fund cannot refuse enrollment to any provider that is determined to be eligible and meets the requirements set forth in the Medical Malpractice Act, thus high risk providers are included in our enrollees.

In 1990, when the PCF Oversight Board took control of the Fund, the Medical Malpractice Act mandated that the fund maintain a 50% surplus above reserves, expenses and surcharge premiums. To attempt to instantly meet this statutory requirement would have required an enormous rate increase (probably close to 200%). This would have caused a great hardship on the health care providers across the state, as well as the health insurance companies and patients that would have to absorb some of the increase. Further, such a rate increase would not have been approved by the Louisiana Insurance Rating Commission. As a result, each year for 13 years, the Legislative Auditor issued a finding against the agency for failing to maintain the required surplus. The Oversight Board's main objective was to make the Fund financially stable. This was necessary for longevity.

Since the PCF is a State agency and not an insurance company, it was felt the required surplus level could be lowered without actually impacting the financial soundness of the Fund. By statutory change in 2002, the Fund is now mandated to maintain at least a 30% surplus.

Through prudent financial strategies, the Board has managed to close the gap between the actual surplus and the mandated surplus. In 1995, five years after the Board took over the Fund, the Fund had managed to reach only a 9% surplus. By July 2002, the surplus had reached 23%. In 2005, the Fund surplus reached 36%, above the minimum now required by the Medical Malpractice Act. The Board has accomplished one of the goals of its creation; a financially sound Fund.

The Fund will continue to meet its obligation to pay claims, while at the same time attempting to keep surcharge rates at reasonable levels, and encourage healthcare providers to stay in Louisiana.

National Practitioners Data Bank

The National Practitioners Data Bank (NPDB) was developed through the enactment of the Health Care Quality Improvement Act passed by the United States Congress in 1986. The NPDB was established due to the ever increasing litigation evolving from medical malpractice and the need to improve medical care throughout the country.

The NPDB began maintaining records of medical malpractice claim payments made on behalf of physicians, dentists and other health care practitioners on September 1, 1990. The information collected and maintained by the data bank is only made available to organizations engaged in the professional review of these practitioners.

Certain entities including the PCF are required to report any claim payment made on a licensed practitioner within 30 days of the payment. The report should include a detailed narrative to describe the acts or omissions and injuries upon which the medical malpractice action or claim was based. Regardless of how the amount paid was determined, whether through a compromised settlement or court ordered judgment, the information must be submitted to the data bank within the 30 days. As stated specifically in the 1986 Act, "[A] payment made in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred." Most understand many claims may be settled for convenience or strictly economic reasons and not due to any alleged malpractice of the practitioner. Payments made on behalf of an entity such as a clinic, hospital or group practice but not attributable to an individual practitioner are not required to be reported. Failure to report this information within the 30 day window could result in a fine of up to $10,000 per offense.

When a report is submitted the NPDB sends a notification of the submission and a copy of the report to the practitioner for whom the report was made. The PCF does not send a copy of the report to the health care provider. A copy is sent to the appropriate state licensing board. In addition any practitioner can make a self-query to determine if they have been the subject of a report. The practitioner can also file a dispute on any information they feel is inaccurate. The data bank cannot correct the report but will submit the dispute to the reporting entity for correcting if applicable. If the reporting entity declines to change the report the practitioner may request the matter be reviewed by the Secretary of the Department of Health and Human Services. The practitioner must submit supporting documentation for whatever information and requested change is being disputed.

For additional information you may visit the NPDB web site at www.npdb-hipdb.com. If you need assistance, contact the NPDB customer service at 800-767-6732 or email npdb-hapdb@sra.com. Or you may contact the NPDB by mail at P.O. Box 10832, Chantilly, VA 20153-0832

Did You Know?

Under the PCF rules, health care providers are required to provide information relative to claims against them. It is their responsibility to keep the PCF staff informed as a claim progresses, especially if it is one that might financially impact the PCF. The rules regarding reporting to the PCF can be found on the PCF web site at: www.lapcf.louisiana.gov.

Chapter 11 of the rules state that the health care provider or the insurer of the health care provider *shall* give not less than 10 days prior written notice to the PCF of any proposed settlement. The Rules further state that the health care provider or the insurer of the health care provider *shall* furnish a copy of any lawsuit and amending pleadings to the PCF. Noncompliance with these rules *shall* be deemed adequate and sufficient legal grounds for cancellation and termination of enrollment. Obviously, the Board would prefer not to have to cancel coverage because a health care provider's insurer failed to comply with the rules. However, it is important for the health care provider to be aware of the possibility and take the necessary steps to ensure the PCF is kept properly informed.

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What's on Your Mind?

The Louisiana Patient's Compensation Fund is YOUR Fund. LPCF Quarterly is OUR publication, developed and provided with the goal of increasing awareness, offering assistance and providing knowledge to YOU.

Is there a "gray" area about the LPCF you would like more information about? Is here a particular topic you'd like addressed? Please visit the LPCF website Feedback Forum http://www.lapcf.louisiana.gov/feedback.htm LPCF welcomes your input about future articles and issues you'd like to see in LPCF Quarterly.

Let LPCF Quarterly be your gateway to knowledge and interaction in the medical malpractice arena.

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